Note: The service definitions for community support for adults and children have been revised effective January 1, 2009. Other service definitions are currently undergoing revision; utilization review statements were updated June 11, 2009. Please check the DMA policy index page (http://www.ncdhhs.gov/dma/mp/) frequently to see updates as they become available.

Community Support—Children/Adolescents (MH/SA): Medicaid Billable Service

Service Definition and Required Components

Community Support services are community-based rehabilitative services and interventions necessary to treat children and adolescents 20 years old or younger (for State-funded services youth 3 through 17 years of age) to achieve their mental health and/or substance abuse recovery goals and to assist parents and other caregivers in helping children and adolescents build resiliency. These medically necessary services directly address the recipient's diagnostic and clinical needs, evidenced by the presence of a diagnosable mental, behavioral, and/or emotional disturbance (as defined by the DSM-IV-TR and its successors), with symptoms and effects documented in a comprehensive clinical assessment and a Person Centered Plan.

Community Support services, are community-based, rehabilitative in nature, and intended to meet the mental health and/or substance abuse needs of children and adolescents who have significant identified symptoms that seriously interfere with or impede their roles or functioning in family, school, or community. These services are designed to

- enhance the skills necessary to address the complex mental health and/or substance abuse symptoms of children and adolescents who have significant functional deficits due to these disorders, to promote symptom reduction and improve functioning in their daily environments;
- assist the child/adolescent and family in acquiring the necessary skills for reaching recovery from mental health and/or substance abuse disorders, for self management of symptoms and for addressing vocational, housing, and educational needs;
- link recipients to, and coordinate, necessary services to promote clinical stability and meet the mental health/substance abuse treatment, social, and other treatment support needs while supporting the emotional and functional growth and development of the child; and
- monitor and evaluate the effectiveness of delivery of all services and supports identified in the Person Centered Plan.

The rehabilitative service activities of Community Support consist of a variety of interventions that must directly relate to the recipient's diagnostic and clinical needs as reflected in a comprehensive clinical assessment and goals outlined in the Person Centered Plan.

These shall include the following, as clinically indicated:

- Facilitation of the Person Centered Planning process with the Child and Family Team which includes the child, parent or legal guardian, and others identified as important in the recipient's life (e.g., family, friends, providers);
- Identification of strengths that will aid the child and family in the child's recovery, as well as the identification of barriers that impede the development of skills necessary for functioning in the community that will be addressed in the Person Centered Plan;
- Initial development, implementation, and ongoing revision of Person Centered Plan;

- Monitoring the implementation of the Person Centered Plan, including involvement of other medical and non-medical providers, the child and the family, and other natural and community supports;
- Individual (1:1) interventions with the child or adolescent, unless a group intervention is deemed more efficacious;
- Therapeutic interventions that directly increase the acquisition of skills needed to accomplish the goals of the Person Centered Plan;
- Identification and self-management of symptoms;
- Identification and self-management of triggers and cues (early warning signs);
- Monitoring and evaluating the effectiveness of interventions as evidenced by symptom reduction and progress toward goals identified in the Person Centered Plan
- Direct preventive and therapeutic interventions, associated with the mental health or substance abuse diagnosis that will assist with skill building related to goals in the Person Centered Plan as related to the mental health or substance abuse diagnosis and symptoms;
- Direct interventions in escalating situations to prevent crisis (including identifying cues and triggers);
- Assistance for the youth and family in implementing preventive and therapeutic interventions outlined in the Person Centered Plan (including the crisis plan);
- Response to crisis 24/7/365 as indicated in the recipient's crisis plan and participation in debriefing activities to revise the crisis plan as needed;
- Relapse prevention and disease management strategies;
- Psychoeducation regarding the identification and self-management of prescribed medication regimen, with documented communication to prescribing practitioner(s);
- Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs identified in the Person Centered Plan. Psychoeducation services and training furnished to family members and/or caregivers must be provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual. Psychoeducation imparts information to the recipients, families, caregivers, and/or other individuals involved with the recipient's care about the recipient's diagnosis, condition, and treatment for the express purpose of helping to assist with developing coping skills. These skills will support recovery and encourage problem solving strategies for managing issues posed by the recipient's condition. Psychoeducational activities are performed for the direct benefit of the Medicaid recipient and help the recipient develop increasingly sophisticated coping skills for handling problems resulting from their condition. The goal of psychoeducation is to reduce symptoms, improve functioning, and meet the goals outlined in the Person Centered Plan.
- Coordination and oversight of initial and ongoing assessment activities; and
- Ensuring linkage to the most clinically appropriate and effective services.

The Qualified Professional drives the delivery of this rehabilitation service. In partnership with the youth and his or her family, and the legally responsible person (if applicable), the Community Support Qualified Professional is responsible for convening the Child and Family Team, which is the vehicle for the person-centered planning process. The Community Support Qualified Professional has ongoing clinical responsibility for initiating, developing, implementing, and revising the Person Centered Plan.

The Community Support Qualified Professional must consult with the child/adolescent and his or her family, legally responsible person, natural supports and identified providers, include their input in the Person Centered Planning process, inform all involved stakeholders, and monitor the status of the recipient in relationship to the treatment goals. Community Support staff inform the recipient and legally responsible person about benefits, community resources, and services; and assist the recipient in accessing benefits and services. The organization assumes the roles of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient.

The Community Support Qualified Professional provides coordination of movement across levels of care by interacting directly with the child/adolescent and his or her family and by coordinating discharge planning and community re-entry following hospitalization, residential services, and other levels of care. The Community Support Qualified Professional provides and oversees services to arrange, link, monitor, and/or integrate multiple services as well as assessment and reassessment (e.g., changes in life domains) of the recipient's need for services.

For Medicaid-funded Community Support services, a signed service order that is part of the Person Centered Plan is required. This must be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to his or her scope of practice, along with other documentation requirements outlined in this policy (DMA Clinical Coverage Policy 8A, *Enhanced Mental Health and Substance Abuse Services*). The service order must be based on an individualized assessment of the recipient's needs. For State-funded services, it is recommended that a service order be completed within the first visit.

Provider Agency and Service Requirements

The service must be ordered by a physician, licensed psychologist, physician assistant or nurse practitioner in accordance with the Person-Centered Planning Instruction Manual. The providers of this service will also serve as a "first responder" in a crisis situation. The service will be provided by an endorsed community support agency. The endorsement process includes Community Support service specific checklist, and adherence to the following:

- Rules for MH/DD/SA Facilities and Services;
- Confidentiality Rules;
- Client Rights Rules in Community MH/DD/SA Services;
- Records Management and Documentation Manual for Providers of Publicly Funded
- MH/DD/SA Services, CAP-MR/DD Services and LMEs;
- Implementation Updates to rules, revisions and policy guidance; and
- North Carolina DMH/DD/SAS Person-Centered Planning Instruction Manual.

Community Support services must be delivered by practitioners who are employed by mental health or substance abuse provider organizations that

- meet the provider qualification policies, procedures, and standards established by the Division of Medical Assistance (DMA);
- meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS);
- fulfill the requirements of 10A NCAC 27G; and
- employ at least one full-time licensed professional.

These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Additionally, within one year of enrollment with Medicaid as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. (Providers who were enrolled prior to July 1, 2008, must have achieved national accreditation within three years of their enrollment date.) The organization must be established as a legally constituted entity capable of meeting all of the requirements of the Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins, and service implementation standards. This includes national accreditation within the prescribed timeframe.

For Medicaid services, the organization is responsible for obtaining authorization from the Medicaid-approved vendor for medically necessary services identified in the Person Centered Plan. For State-funded services, the organization is responsible for obtaining authorization from the Local Management Entity for the medically necessary services identified by the Person Centered Plan. The Community Support provider organization must comply with all applicable federal, state, and DHHS requirements. This includes, but is not limited to, DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

The agency must have a full time licensed clinical professional on staff. The community based service is provided by qualified professionals, paraprofessionals and associate professionals, who must have a minimum of 20 hours of training specific to the requirements of the service definition within the first 90 days of employment.

In addition, persons employed or contracted must meet the requirements specified (10A NCAC 27G .0104) for Qualified Professional (QP), Associate Professional (AP), and Paraprofessional status, as defined on Attachment 3.1-A.1, Pages 7c.3d through 7c.3f of the Community Support State Plan Amendment , and who have the knowledge, skills, and abilities required by the population and age to be served, may deliver Community Support services. Associate Professionals and Paraprofessionals will deliver Community Support services to address directly the recipient's diagnostic and clinical needs under the direction of the Qualified Professional.

All Associate Professionals and Paraprofessionals providing Community Support services must be supervised by a Qualified Professional. Supervision* must be provided according to supervision requirements specified in 10A NCAC 27G .0204 and according to licensure or certification requirements of the appropriate discipline. These staff must also demonstrate compliance with the identified competencies in the areas of participating empowerment, communication, clinical knowledge, community and service networking, implementation of person centered services, advocacy, crisis prevention and intervention and documentation. Non–Post-Graduate degreed Qualified Professionals must be supervised by a Master's Level Qualified Professional, preferably Licensed.

*Supervision of Community Support is covered as an indirect cost and therefore should not be billed separately as Community Support.

The Licensed Professional or Qualified Professional has sole responsibility for

- Facilitation of the Person Centered Planning process for rehabilitative services through the Child and Family Team, which includes the active involvement of the child/adolescent, family members, legally responsible person, and others identified as important in the recipient's life (e.g., friends, providers);
- Initial development, implementation, and ongoing revision of Person Centered Plan for rehabilitative services;
- Monitoring and evaluating the effectiveness of interventions as evidenced by symptom reduction and progress toward goals identified in the Person Centered Plan for rehabilitative services. The non-licensed Qualified Professional must seek clinical input as needed in monitoring and assessing the effectiveness of the PCP.;
- Coordination and oversight of initial and ongoing assessment activities; and
- Ensuring linkage to the most clinically appropriate and effective rehabilitative services

The Licensed Professional or Qualified Professional may also perform the activities, functions, and interventions of the Community Support service definition included in the chart below. The Qualified Professional or Licensed Professional must deliver a minimum of 25% of Community Support services. Effective March 2, 2009, a minimum of 35% of community support services must be delivered by Qualified Professionals or Licensed Professionals. Effective September 2, 2009, a minimum of 50% of community support services must be delivered by Qualified Professionals or Licensed Professionals.

The following chart sets forth the activities included in this service definition. These activities reflect the appropriate scope of practice for the Community Support staff identified below.

Community Support Services	
Professional Services	Skill Based Interventions
May only be provided by the Qualified Professional. Unlicensed Qualified Professionals must not provide therapeutic interventions that would require a license; however, the therapeutic interventions outlined below do not require a licensed professional.	May be provided by the Qualified Professional, the Associate Professional (under the supervision, direction, and oversight of the Qualified Professional or Licensed Professional), or the Paraprofessional (under the supervision, direction, and oversight of the Qualified Professional or Licensed Professional)
• Therapeutic interventions that directly increase the acquisition of skills needed to accomplish the goals of the Person Centered Plan. • Psychoeducation regarding the identification and self-management of prescribed medication regimen, with documented communication to prescribing practitioner(s). *(continues)*	• Provision of skill-building interventions to rehabilitate skills negatively affected by their mental health and/or substance abuse diagnosis o Functional skills o Socialization, relational, and coping skills o Self-management of symptoms o Behavior and anger management skills. *(continues)*

Community Support Services	
Professional Services	Skill Based Interventions
• Direct preventive and therapeutic interventions that will assist with skill building related to goals in the Person Centered Plan. • Direct interventions in escalating situations to prevent crisis (including identifying cues and triggers). • Assistance for the child/adolescent and family in implementing preventive and therapeutic interventions outlined in the Person Centered Plan (including the crisis plan). • Response to crisis 24/7/365 as indicated in the recipient's crisis plan and participation in debriefing activities to revise the crisis plan as needed. • Relapse prevention and disease management strategies. • Psychoeducation of family, unpaid caregivers, and others who have a legitimate role in addressing the needs identified in the Person Centered Plan. • Ongoing assessment activities (observation and ongoing activities to address progress or lack thereof) of this service. • Initial development and ongoing revision of Person Centered Plan through ongoing clinical involvement in the Child and Family Team. • Assessing, documenting, and communicating the status of the recipient's progress and the effectiveness of the strategies and interventions of this service to the Child and Family Team as outlined in the Person Centered Plan. • Supportive counseling to address the diagnostic and clinical needs of the recipient. • Supervision by the Qualified Professional of Community Support activities provided by Associate and Paraprofessional staff. • The Qualified Professional is responsible for all the activities and interventions of this service.	• Implementation of preventive and therapeutic interventions that will facilitate skill building. • Identification and self-management of symptoms • Identification and self-management of triggers and cues (early warning signs). • Input into the Person Centered Plan modifications.

Family members or legally responsible persons of the recipient may not provide these services for reimbursement.

Provider (Staff) Qualifications

All staff that provide services must have a minimum of 20 hours of training specific to the requirements of the service definition within the first 90 days of employment.

- 6 hours service definition specific training
- 3 hours crisis response training
- 6 hours Person Centered Thinking training
- QP staff responsible for Person Centered Plan (PCP) development—3 hours PCP Instructional Elements training
- 2–5 hours in other topics related to service and population(s) being served.

Training required for other purposes, such as Alternatives to Restrictive Intervention, client rights and confidentiality, and infectious diseases and bloodborne pathogens, may not be counted to achieve any of the 2–5 hours of additional training needed (for example, as found in 10A NCAC 27E .0107 and 10A NCAC 27G .0202).

In addition, persons employed or contracted must meet the requirements specified (10A NCAC 27G .0104) for Qualified Professional (QP), Associate Professional (AP), and Paraprofessional status, as defined on Attachment 3.1-A.1, Pages 7c.3d through 7c.3f, of the Community Support State Plan Amendment, and who have the knowledge, skills, and abilities required by the population and age to be served, may deliver Community Support. Associate Professionals and Paraprofessionals will deliver Community Support services to address directly the recipient's diagnostic and clinical needs under the direction of the Qualified Professional.

All Associate Professionals and Paraprofessionals providing Community Support must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G .0204 and according to licensure or certification requirements of the appropriate discipline. These staff must also demonstrate compliance with the identified competencies in the areas of participating empowerment, communication, clinical knowledge, community and service networking, implementation of person centered services, advocacy, crisis prevention and intervention and documentation. Non–Post-Graduate degreed Qualified Professionals must be supervised by a Master's Level Qualified Professional, preferably Licensed.

Associate Professional (AP) within the mental health, developmental disabilities and substance abuse services (MH/DD/SAS) system of care means an individual who is a

(a) graduate of a college or university with a Masters degree in a human service field with less than one year of full-time, post-graduate degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional with less than one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets one year of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or

(b) graduate of a college or university with a bachelor's degree in a human service field with less than two years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional with less than two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be

provided by a qualified professional with the population served until the individual meets two years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or

(c) graduate of a college or university with a bachelor's degree in a field other than human services with less than four years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional with less than four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually; or

(d) Registered Nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing with less than four years of full-time accumulated experience in MH/DD/SAS with the population served. Supervision shall be provided by a qualified professional with the population served until the individual meets four years of experience. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually.

Paraprofessional (PP) within the MH/DD/SAS system of care means an individual who, with the exception of staff providing respite services or personal care services, has a GED or high school diploma; or no GED or high school diploma, employed prior to November 1, 2001 to provide a MH/DD/SAS service. Supervision shall be provided by a qualified professional or associate professional with the population served. The supervisor and the employee shall develop an individualized supervision plan upon hiring. The parties shall review the plan annually.

Qualified Professional (QP) means, within the MH/DD/SAS system of care:
(a) an individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in MH/DD/SAS with the population served.

The Licensed Qualified Professional will be a Licensed Professional (LP) holding a valid license issued by the governing board regulating a human service profession in the State of North Carolina. Individuals licensed as a Clinical Addiction Specialist, Clinical Social Worker, Marriage and Family Therapist, Professional Counselor, Psychiatrist, or Psychologist. The specific requirements for each of the above licensed professionals are listed below.

- Licensed Clinical Addiction Specialist means an individual who is licensed as such by the North Carolina Substance Abuse Professional Practice Board.
- Licensed Clinical Social Worker means a social worker who is licensed as such by the N.C. Social Work Certification and Licensure Board.
- Licensed marriage and family therapist means an individual who is licensed as such by the North Carolina Marriage and Family Licensing Board.
- Licensed Professional Counselor (LPC) means a counselor who is licensed as such by the North Carolina Board of Licensed Professional Counselors.
- Psychiatrist means an individual who is licensed to practice medicine in the State of North Carolina and who has completed a training program in psychiatry accredited by the Accreditation Council for Graduate Medical Education.

- Psychologist means an individual who is licensed to practice psychology in the State of North Carolina as either a licensed psychologist or a licensed psychological associate, or

If not licensed, the QP will be

(b) a graduate of a college or university with a Masters degree in a human service field and has one year of full-time, post-graduate degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or

(c) a graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional who has two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling; or

(d) a graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional who has four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling.

Degrees in a human service field include but are not limited to, the following degrees: psychology, social work, mental health counseling, rehabilitation counseling, addictions, psychiatric nursing, special education, and therapeutic recreation.

Service Type/Setting

Community Support is a direct and indirect periodic rehabilitative service in which the Community Support staff member provides medically necessary services and interventions that address the diagnostic and clinical needs of the recipient and also arranges, coordinates, and monitors services on behalf of the recipient. Community Support services may be provided to an individual or a group of individuals.

Community Support providers must deliver services in various environments, such as homes, schools, courts, detention centers and jails (State funds only*), homeless shelters, street locations, and other community settings.

Community Support also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his or her rehabilitation goals. Community Support includes participation and ongoing clinical involvement in the Child and Family Team for planning, development, and revision of the recipient's Person Centered Plan.

When children are patients in an Institution for Mental Diseases (IMD), the Qualified Professional may provide 8 units per month of the case management component of this service in order to facilitate transition to community services. This component may not be duplicative of hospital discharge planning.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions (detention centers, youth correctional facilities, jails).

Program Requirements

Caseload size for one full-time equivalent Community Support Qualified Professional may not exceed 1 Qualified Professional to 15 recipients. (Note: in computing caseload ratios, two recipients, each of whom receives fewer than 4 hours of service per week, may be counted as one recipient). Community Support services may be provided to groups of individuals, but groups may not exceed 8 individuals.

For each endorsed provider site and for each authorization period (90 days or less, depending on authorization), a minimum of 25% of the total aggregate billable Community Support services must be provided by the Qualified Professional or Licensed Professional. Effective March 2, 2009, a minimum of 35% of Community Support services must be delivered by Qualified Professionals or Licensed Professionals. Effective September 2, 2009, a minimum of 50% of Community Support services must be delivered by Qualified Professionals or Licensed Professionals. This is to ensure that medically appropriate clinical interventions are provided based on implementation/revision of the required Person Centered Plan.

Program services are primarily delivered face-to-face with the recipient and in locations outside the agency's facility. The aggregate services that have been delivered by the endorsed provider site will be assessed and documented annually by each endorsed provider site using the following quality assurance benchmarks:

- all children/adolescents receiving Community Support must receive a minimum of two contacts per month, with one contact occurring face-to-face with the recipient;
- a minimum of 60% of Community Support services that are delivered must be performed face-to-face with recipients; and
- a minimum of 60% of staff time must be spent working outside of the agency's facility, with or on behalf of recipients.

Eligibility Criteria

Clinical criteria (medical necessity criteria for admission) are presented below:

The recipient is eligible for this service when

A. significant impairment is documented in at least two of the life domains related to the recipient's diagnosis, that impede the use of the skills necessary for independent functioning in the community. These life domains are as follows: emotional, social, safety, medical/health, educational/vocational, and legal.

AND

B. there is an Axis I or II MH/SA diagnosis (as defined by the DSM-IV-TR or its successors), other than a sole diagnosis of Developmental Disability

AND

C. there is a substance abuse diagnosis, American Society for Addiction Medicine (ASAM) criteria is met.

AND

D. the recipient is experiencing functional impairments in at least two of the following areas as evidenced by documentation of symptoms:
   1. is previously or imminently at risk for institutionalization, hospitalization, or placement outside the recipient's natural living environment;
   2. is receiving or needs crisis intervention services;

3. has unmet identified needs related to MH/SA diagnosis as reported from multiple agencies, needs advocacy, and service coordination as defined by the Child and Family Team;
4. is abused or neglected as substantiated by DSS, or is found in need of services by DSS, or meets dependency as defined by DSS criteria (GS 7B101);
5. exhibits intense verbal aggression, as well as limited physical aggression, to self or others, due to symptoms associated with the mental health and/or substance abuse diagnosis, which is sufficient to create functional problems in the home, community, school, job, etc.; or
6. is in active recovery from substance abuse or dependency and is in need of continuing relapse prevention support

AND

E. There is no evidence to support that alternative interventions would be equally or more effective based on North Carolina community practice standards (e.g., Best Practice Guidelines per the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine) as available or based on established utilization review criteria established by the NC Department of Health and Human Services.

Entrance Process

A comprehensive clinical assessment which demonstrates medical necessity must be completed prior to provision of this service.

Relevant diagnostic information must be obtained and included in the Person Centered Plan. If a substantially equivalent assessment is available, reflects the current level of functioning, and contains all the required elements as outlined in community practice standards as well as in all applicable federal, state, and DHHS requirements, it may be utilized as a part of the current comprehensive clinical assessment.

For Medicaid, in order to request the initial authorization, the required Person Centered Plan with signatures and the required authorization request form must be submitted to the Medicaid-approved vendor.

For State-funded Community Support services, prior authorization by the Local Management Entity is required. In order to request the initial authorization, a required Person Centered Plan with signatures, the required authorization request form, and the required PCP Consumer Admission Form must be submitted to the Local Management Entity.

Continued Service Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the Community Support service goals in the recipient's Person Centered Plan; or the recipient continues to be at risk for relapse based on current clinical assessment, history, and the tenuous nature of the functional gains or continues to meet the utilization criteria established by the NC Department of Health and Human Services;

AND

One of the following applies:

A. Recipient has achieved current Community Support goals in the Person Centered Plan and additional goals are indicated as evidenced by documented symptoms.

B. Recipient is making satisfactory progress toward meeting Community Support goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the Person Centered Plan.
C. Recipient is making some progress, but the Community Support interventions in the Person Centered Plan need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
D. Recipient fails to make progress and/or demonstrates regression in meeting the Community Support goals through the strategies outlined in the Person Centered Plan. The recipient's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, with treatment recommendations revised based on findings.

The Child and Family Team, comprised of the providers, recipient and family members who participate in the Person Centered planning process, determine whether the recipient needs to continue the service and meets continued service criteria during a Person Centered plan review process, in which the QP participates and provides clinical guidance. The QP provides clinical oversight, guidance and monitors the clinical process. Based on the Child and Family Team's assessment and recommendation, the provider will then request continued service authorization through Medicaid's utilization management organization which makes the final determination of medical necessity.

Discharge Criteria

Any one of the following applies to the Community Support service:

A. Recipient's level of functioning has improved with respect to the Community Support goals outlined in the Person Centered Plan, inclusive of a transition plan to step down.
B. Recipient has achieved goals and is no longer in need of Community Support services.
C. Recipient is not making progress or is regressing and all reasonable clinical strategies and interventions have been exhausted, indicating a need for more intensive services.
D. Recipient or family/legally responsible guardian no longer wishes to receive Community Support services.
E. Recipient, based on presentation and failure to show improvement despite modifications in the Person Centered Plan, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (e.g., the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association Practice Guidelines, American Society of Addiction Medicine).

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights in accordance with the Department's recipient notices procedure.

In addition, a completed LME Consumer Admission and Discharge Form must be submitted to the LME.

Expected Clinical Outcomes

The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the recipient's Person Centered Plan.

Expected clinical outcomes may include

- Symptom reduction
- Achieve recovery as indicated by

- Improve and sustain developmentally appropriate functioning in specified life domains
- Increase coping skills and social skills that mediate life stresses resulting from the recipient's diagnostic and clinical needs
- Minimize the negative effects of psychiatric symptoms and/or substance dependence that interfere with the recipient's daily living
- Uses natural and social supports
- Utilize functional skills to live independently
- Develop and utilize strategies and supportive interventions to maintain a stable living arrangement and avoid of out-of-home placement

Documentation Requirements

The minimum standard is a daily full service note, including crisis response activities written and signed by the person who provided the service that includes

- Recipient's name
- Medicaid identification number
- Service provided (e.g., Community Support–Individual or Community Support–Group)
- Date of service
- Place of service
- Type of contact (face-to-face, phone call, collateral)
- Purpose of the contact
- Description of the provider's interventions
- Amount of time spent performing the interventions
- Description of the effectiveness of the interventions
- Signature and credentials of the staff member(s) providing the service (for paraprofessionals, position is required in lieu of credentials with staff signature)

The documentation must be in compliance with "Records Management and Documentation Manual for Providers of Publicly Funded MH/DD/SA Services, CAP-MR/DD Services and LMEs."

Utilization Management

Services are based upon a finding of medical necessity, must be directly related to the child or adolescent's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the individual's Person Centered Plan. Medical necessity is determined by North Carolina community practice standards, criteria established by the NC Department of Health and Human Services and as verified by the independent Medicaid utilization management vendor or the Local Management Entity for State-funded services. Prior authorization is required for all community support services. This initial prior approval process will ensure that the level of the service is appropriate and concurrent reviews will determine the ongoing medical necessity for the service or the need to move up or down the continuum of services to another level of care.

Units are billed in 15-minute increments and must include the modifier to denote level of staff providing the service.

Community Support services are provided on an individual basis unless a group intervention is determined to be more efficacious. Community Support -- Group is defined as providing Community Support services to a group consisting of no more than eight individuals.

Typically, the medically necessary service must be generally recognized as an accepted method of medical practice or treatment. Each case is reviewed individually to determine if the requested service meets the criteria outlined under EPSDT.

This medically necessary service is authorized in the most cost efficient mode, as long as the treatment that is made available is similarly efficacious to services requested by the recipient's physician, therapist or other licensed practitioner.

For Medicaid, authorization by the Medicaid-approved vendor is required according to published policy.

For State-funded Community Support services, authorization by the Local Management Entity is required prior to the first visit. The Medicaid-approved vendor or the Local Management Entity will evaluate the request to determine if medical necessity supports more or less intensive services.

Medicaid may cover up to 32 units per week, based on the medical necessity documented in the required Person Centered Plan, the Medicaid vendor's authorization request form, and supporting documentation.

For State-funded services, the Local Management Entity will determine the initial authorization period. A required Person Centered Plan, a request for authorization, and supporting documentation reflecting the appropriate level of care and service must be submitted to the Local Management Entity.

If continued Community Support services are needed at the end of the initial authorization period, the required Person Centered Plan and a new request for authorization reflecting the appropriate level of care and service must be submitted to the Medicaid-approved vendor for Medicaid services, or to the Local Management Entity for State-funded services. This must occur prior to the expiration of the initial authorization. Failure to request a reauthorization prior to the expiration date will result in a denial of payment and will be considered an initial authorization for purposes of determining eligibility of maintenance of service.

No additional Community Support services may be requested without a required Person Centered Plan and a new request for authorization reflecting the appropriate level of care and service must be submitted to the Medicaid-approved vendor for Medicaid services, or to the Local Management Entity for State-funded services.

Service Exclusions and Limitations

A child or adolescent may receive Community Support services from only one Community Support provider organization at a time.

There are limitations indicated to prevent this service from being provided while a child is in an inpatient setting or in an Institution for Mental Disease, or an intensive in-home service, Multi-Systemic Therapy, partial hospitalization, PRTF, substance abuse residential service, or intensive substance abuse service with the exception of 8 units per month in the case management component of the service as delineated below.

For the purposes of facilitating an admission to a service, making a transition to or from a service, ensuring that the service provider works directly with the Community Support Qualified Professional, and/or discharge planning, Community Support–Individual services may be billed for a maximum of 8 units per 30-day period for individuals who are authorized to receive one of the following services during the same authorization period:

- Child and adolescent day treatment
- Intensive in-home services*
- Multisystemic therapy*
- Partial hospitalization
- Substance abuse intensive outpatient program*
- Levels II Program Type through Level IV child residential treatment
- Substance abuse residential services
- PRTF
- Inpatient services

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary. [See **Subsection 2.2, EPSDT Special Provision,** in this policy (Clinical Coverage Policy 8A, *Enhanced Mental Health and Substance Abuse Services*).]

***Provider of these services is responsible for the Person Centered Plan and all other clinical home responsibilities.**